C-42

Plan for a

Village Health Programme

Using

Village Health Workers

Patricia F. Wakeham

EMMANUEL HOSPITAL ASSOCIATION

VOLUNTARY HEALTH ASSOCIATION OF INDIA

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GENERAL INTRODUCTION

Many people are interested in community health and are eager to develop some form of community health outreach as an extension of their existing medical work. They have read much on the subject and may have been to see projects in action, but still they find it difficult to apply what they know in their own situation. It is not that they lack ideas but they face the problem of how to reduce those ideas to writing to produce a definitive plan for the programme. Yet without such a plan a programme loses direction and the workers are unsure of what is expected of them.

It is for this reason that we publish this plan which was drawn up for one of the EHA hospitals. Since it was written for a specific situation some of the details will be irrelevant to other programmes. It is one of the fascinations of Community Health that no two programmes are quite the same since no two communities are exactly alike. Each programme must be adapted to the community in which it is to be implemented and each will have its own distinctive flavour. But it is our hope that these pages may serve as a guide for those who have the responsibility of developing community health outreach and that it may encourage them in the task of writing their own programme.

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The Initial Plan of A Health Project

Introduction

Programme planning is not something which happens overnight but it is a progressive process which follows definable steps:

1. *Formulating* a tentative plan—Ideas for the programme are sorted through and ordered into what it is hoped will be a workable plan. This may or may not be written. Ideally representatives of the community to be served are involved in the planning even at this early stage.

2. *Testing* the plan—The tentative plan is tried out. Problems encountered, especially negative reactions from the community, are noted and the plan modified accordingly.

3. *Writing* the definitive plan—At this stage the modified plan is written up as the definitive plan of the programme. This sets the direction of the programme and this point on, all workers must stick to the objectives and methodology laid down in the plan.

4. *Implementing* the plan—The programme goes into action. The ideas of the plan are implemented in the activities of the programme.

5. *Evaluating* the programme—The programme is assessed to see how far the objectives laid down in the plan are being achieved through the activities of the programme. If achievement is satisfactory then the programme can continue along its present course.

6. *Revising* the plan—If achievement is not satisfactory than the plan needs revision. To do this the problem must first be diagnosed and the possible remedies discussed. The fault may lie with the objective (set too high) —the remedy is to revise the objective. Or it may be with the activity—it is off target and therefore failing to achieve

its objective. In this case the activity needs revision.

In the plan which follows (which represents step 3 of the planning process) it will be noticed that statements are made dogmatically, i.e. this *will* happen. It is important always to write plans positively like this. They are the blueprint which defines and gives direction to the programme. However, there needs to be a flexibility in the implementation of the plan and a readiness to revise the plan whenever problems are met. The revised plan is formulated, tested, then written into the programme as positively as the plan it replaces.

Where the Panchayat expresses interest in the programme, the following propositions will be put to them:

1. Training of Village Health Workers

1.1. The aim of the programme is to provide basic health care at the village level through the training of Village Health Workers (V.H.W.S)

1.2. The Panchayat will be responsible for providing the salary of the V.H.W., the rate to be decided on by the Panchayat in consultation with the hospital.

1.3. The salary of the V.H.W. will be paid every four weeks in the presence of Panchayat and hospital representatives.

1.4. The first payment will fall due when the V.H.W. successfully completes the initial course of training.

1.5. Failure to provide the salary on time will result in the withdrawal of all hospital services from the village.

1.6. V.H.W. Training will include the following:

Principles of hygiene and disease prevention
Nutrition and the right use of foods.
Mother and child care including the hygienic conduct of delivery.
Recognition of certain common diseases and when to call the doctor.
Treatment of certain common diseases.

2. Charge for treatment

2.1. A scale of charges for treatment will be drawn

up by the hospital and a copy of this will be given to the Panchayat.

2.2. The V.H.W. is allowed to charge for treatment according to this agreed rate, but she is not to charge for her services.

2.3. On the satisfactory completion of her initial training the V.H.W. will be provided with a basic medicine pack by the hospital. Thereafter she will be able to buy replacement medicines from the hospital at the agreed rate, using the money she has received for treatment given. Thus her stock is self-perpetuating.

2.4. Complaints that the V.H.W. is taking more money than the agreed rate should be dealt with by the Panchayat.

2.5. Complaints by the V.H.W. that the people are demanding free treatment and putting pressure on the V.H.W. will be dealt with by the doctor in charge of the programme in consultation with the Panchayat. If complaints persist, all services to the village will be withdrawn.

2.6. Normally the V.H.W. will not give out any medicines to those who are unable to pay. In an emergency she may decide to do so but all such cases must be reported to the doctor at the earliest opportunity so that he can check whether her decision was justified. Otherwise she will have to pay for replacement medicine in the normal way. Non-urgent cases who request free treatment should be referred to the doctor's clinic.

3. The weekly clinic

3.1. A weekly clinic will be held in each village served. The purpose of this clinic is to provide a supporting service for the V.H.W., and patients will be seen on a referal basis—i.e. referred by the V.H.W. to the clinic and referred back from the clinic to the V.H.W.

3.2. The clinic will be in two sections:

(i) M.C.H. clinic—for immunisations and weight-recording. (initially the Community Health Nurse (CHN) will also be doing routine antenatal

examinations and giving simple treatments until the V.H.W. is competent to do this.)

(ii) Doctor's clinic—for conditions which the V.H.W. is not competent to treat. The doctor will see women and children who are referred to him either directly or via the M.C.H. clinic. Men may be seen on a direct consultation basis.

3.3. Clinic charges will be on the following basis.

(i) Consultation fee—for those who see the doctor.

(ii) Laboratory fee—set charges according to tests requested.

(iii) Treatment charge—on the same scale as the V.H.W.'s list of charges.

A list of these fixed charges will be given to the Panchayat. They will be revised from time to time to allow for the changing prices of medicines.

The Panchayat will be asked to draw up a list of poor families who should qualify for free treatment. The list will be available to the Panchayat and the hospital. All other patients will be expected to pay according to the agreed rates.

3.4. Immunisations will as far as possible be given free. If free supplies cannot be obtained the hospital will discuss with the Panchayat the possible alternatives.

3.5. Clinic facilities should for the most part be provided by the Panchayat. Minimum requirements will be :

(i) Accommodation : 2 rooms, preferably in different parts of the village, one for M.C.H. Clinic and one for Doctor's Clinic

(ii) Furnishings : 1 dari, 1 charpoi, for M.C.H. Clinic 2 tables, 3 chairs, 1 charpoi, for Doctor's Clinic.

The Panchayat will be responsible to see that these are available each week, otherwise services may have to be withdrawn.

3.6. Referrals to hospital will only be made for conditions which cannot be treated in the village. These will be mainly surgical conditions. Referral slips will be given and the patient will be free to choose which hospital to go to. Concessions in fees will be available.

4. Village Health Committee

4.1. Each village will be encouraged to set up a village health committee.

4.2. This committee will discuss the community health programme and other health-related topics with the doctor on a regular basis. They should take an active interest in the programme and offer suggestions for improvements.

4.3. They will normally be responsible for day to day decisions regarding village health, acting on behalf of the Panchayat and responsible to them.

If the Panchayat agrees to these propositions a date will be set for the commencement of the V.H.W. Training Programme, and the time of the weekly clinic will be decided.

ACTIVITIES

1. The Training of Village Health Workers

The object of V.H.W. training is to provide health care to the villagers in their own community. Since the most vulnerable groups are children under five and women of child-bearing age, priority will be given to the training of village women as health workers.

Suitable women who are approved by the Panchayat will be invited to attend a weekly training class in the village. The preliminary course will be in three sections :

(1) Health and Hygiene
(2) Maternal and Child Health, including Nutrition
(3) Diagnosis and treatment of certain common diseases.

Sections (1) and (2) will contain approximately eight lessons each while section (3) will contain at least twice that number. It is immaterial whether section (1) is studied

before section (2) or vice versa, but section (3) cannot be commenced until sections (1) and (2) have been satisfactorily completed.

Trainees will be continuously assessed to determine their progress and they will be observed to see if they are putting into practice what they are being taught. This will enable unsuitable candidates to be detected early and withdrawn from the training programme. In addition, there will be an oral and practical examination at the end of each section which must be passed before the trainee can proceed to the next section. A failed candidate must spend at least one month revising a section before she can repeat the examination.

Besides V.H.W. trainees, other interested women may attend the training sessions of sections (1) and (2), but section (3) training will be restricted to the trainees chosen by the Panchayat in consultation with the hospital. Thus, section (3) training will not commence until agreement has been reached regarding terms of employment of the V.H.W.

During section (3) training medicines will be issued progressively. The V.H.W. must show that she is completely conversant with the use of one drug before she is issued with the next, and initially she will present every case she treats to her supervisor on her next visit. The supervisor will constantly revise with her the use of drugs already issued.

On satisfactory completion of section (3) training the V.H.W. will be issued with her basic medicine pack, and the Panchayat will assume responsibility for her salary.

The time span for this initial training is likely to be one year :

Section (1)	—	3 months
Section (2)	—	3 months
Section (3)	—	6 months

Every effort should be made to keep within this time schedule, otherwise the trainees are liable to lose interest.

However, the schedule should be kept flexible to allow for pressing commitments (e.g. harvesting) which prevent the women attending classes at certain times of year.

Following this initial training period continuous in-service training will take place during the weekly or fortnightly visit of the supervisor for the M.C.H. clinic.

2. Establishment of M.C.H. and Doctor's Clinics

As stated previously the purpose of the weekly clinic is to provide a supporting service for the V.H.W. It will also provide a training session, initially to reinforce the teaching being given in the training session, and later to give advice on the problems which the V.H.W. encounters in the course of her work.

The clinic will be held in two sections, one for M.C.H. and one for doctor's consultations, and these will follow one another so that the V.H.W. can be present at both.

M.C.H. Clinic. On arrival at the village the Community Health Nurse (C.H.N.) and her assistant will join the V.H.W. in the M.C.H. Clinic. It will be the responsibility of the V.H.W. to go round the village before hand to encourage those women and children who need to be seen to come to the clinic. This will ensure that they are gathered together when the team arrives rather than drifting in slowly afterwards.

The maximum duration of the clinic should be $1\frac{1}{2}$ hours.

The clinic will include health talks for the mothers (given jointly by the C.H.N. and the V.H.W. in order to reinforce the authority of the V.H.W.), examinations of ante-natal and post-natal cases, and of under-fives, immunisations, and instruction of the V.H.W. in the management of cases with which she is unfamiliar.

Following the M.C.H. Clinic, the V.H.W. will join the Doctor's Clinic along with those cases she is referring to him.

Doctor's Discussions While the M.C.H. Clinic is in progress the doctor and his assistant will consult with village leaders on any matters relating to the project or to village

health in general, and they will also give health talks to the men of the village.

This activity should take approximately one hour.

Doctor's Clinic The doctor's clinic will commence approximately one hour after arrival in the village. The doctor will begin by seeing anyone who requires treatment. These will come directly to him for consultation. (However, if a training programme for male V.H.W.s is developed, male consultation will then be on a referral basis parallel to that for women and children). Women and children may not be seen by direct consultation but only on the recommendation of the V.H.W. A diagramatic representation of the referral system is given below :

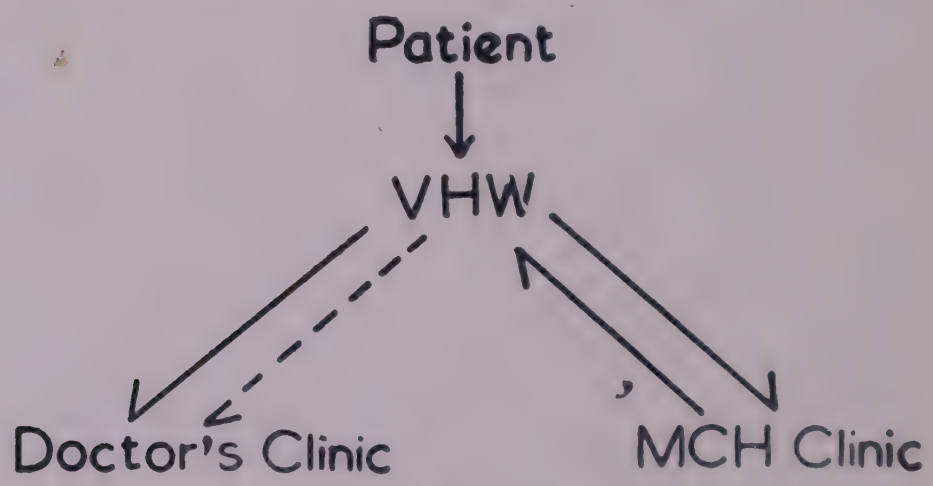

Fig. 1

Consultation with women and children should always be carried out in the presence of the V.H.W. so that the doctor can instruct her regarding management and followup.

Time may need to be allowed for consultation in homes in cases where it is in the patient's or community's interest that they should not attend the clinic (e.g. severe heart failure, infectious disease). Such cases should be kept to a minimum and care must be taken to see that this service is not abused.

The maximum time allowed for the Doctor's Clinic shouid be 1½ hours, plus a further 1/2 hour for home consultations, giving a total time in the village of 3 hours (see fig. 2)

3. Development of Referral System

Certain health problems cannot be adequately treated in the village situation. Such problems include surgical conditions requiring operation, complicated obstetrics, and medical conditions requiring elaborate investigations.

Non-urgent cases should be referred by the V.H.W. to the doctor on the next clinic day. The doctor will then advise the patient regarding the treatment which is required, and where such treatment can be obtained. The doctor will write a letter of referral to the appropriate hospital. Where the.....Hospital can provide the necessary treatment, (this will be particularly in relation to obstetric cases) a concession will be available on consultation fees.

Urgent cases should be referred directly to the..... .....Hospital by the V.H.W. without awaiting a doctor's opinion. The V.H.W. should be encouraged to err on the side of sending in patients unnecessarily rather than risk

The Weekly Clinic—Diagram of Activities & Staff Deployment

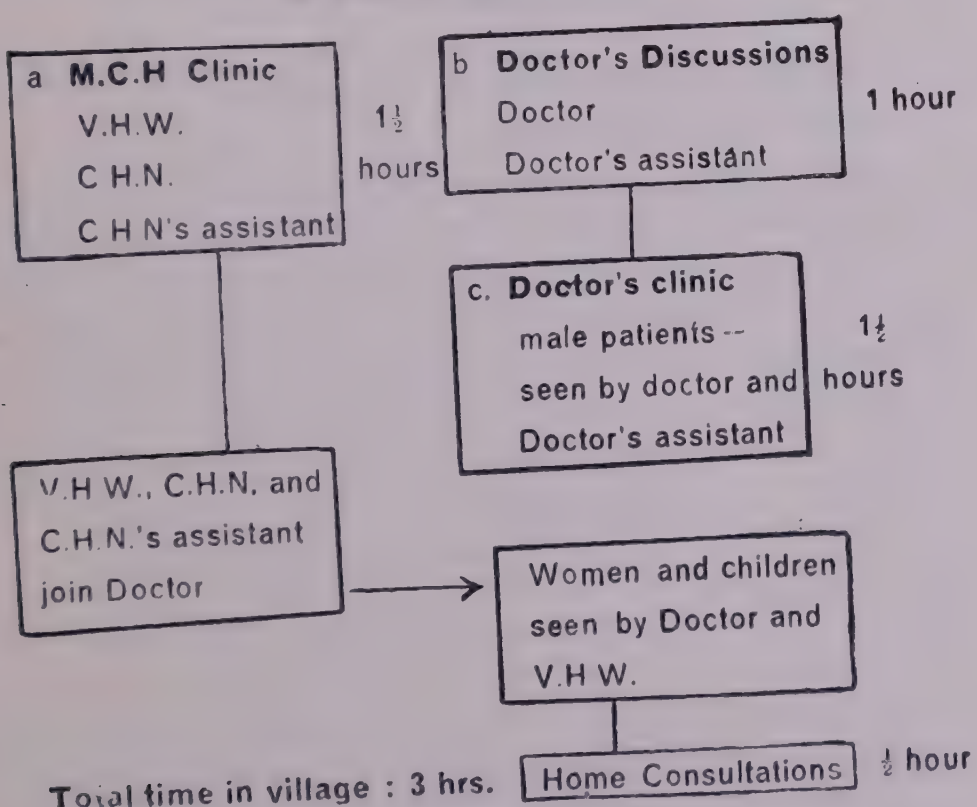

Fig. 2

the consequences of delay. The doctor at the hospital can then decide if they need transfer elsewhere for treatment.

The Panchayat should be approached regarding transport facilities for seriously ill patients and should be encouraged to take responsibility for this. They should also be asked to devise some scheme to meet the costs of hospitalisation of villagers who cannot afford to pay themselves. This could take the form of a charity or an insurance scheme.

The hospital should also decide what their policy will be in terms of charity concessions to deserving patients.

EVALUATION

Introduction

In order to evaluate the programme it is essential to keep adequate records from which statistics can be compiled. However, statistics become a burden unless the following principles are adhered to :

1. Statistics should serve the programme, not be the object of it

Most programmes, if they keep statistics at all, err on the side of collecting too much data. This is because most programmes which have been written up in the literature have been research programmes concerned with gathering information as much as serving the needs of the people. In deciding what records are necessary it is wise to ask what purpose they serve—will the information gained influence future plans for the programme? If so, then it is definitely worthwhile keeping these records. But if not, it has no practical value. It will not benefit the community at all and is of academic interest only. Such records are superfluous.

2. *Records should be kept simple* so that every member of the team knows how to enter data correctly. As far as possible record forms or registers should be self-explanatory.

3. *The purpose of records and statistics should be fully explained* to all the team so that they can appreciate the need for the extra work which is involved. If team members are shown the interesting information gleaned from the statistics they have kept, they will appreciate the value of this work and will do it more willingly.

In deciding what records and statistics were necessary in this particular programme the following questions were asked :

What are the objectives of the programme ?
How can achievement of objectives be evaluated ?
What information is necessary to do this evaluation ?
How can the information be collected ?

It will be seen that the information required can be collected very simply and does not need the detail of an average survey form.

The only other records which are being kept relate to village health activities. Although these do not directly serve the objectives they do give valuable information regarding the impact of the programme on village health. They give answers to such questions :

1. What are the principle health problems ? Are they the conditions which are receiving priority in the programme ? Is there any change in disease patterns as a result of the programme ?

* What sort of coverage is being achieved in immunisation programmes? Is it adequate or is a change of strategy needed?
* Are all sections of the community being served equally? If not, who are the underprivileged and how can they be reached?

In addition, information on village health activities forms the basis of regular reports to the DMO so that he is fully informed of what is going on in his district.

Evaluation of Village Health Worker Training

The following evaluative measures are suggested:

Village Health Worker Training—At the end of one year progress in V.H.W. training will be reviewed:

* How many villages have been approached about participating in the community health programme and in how many of these has V.H.W. training got under way? (This will indicate if approach to village leaders is right or needs modifying).
* Is the training programme proceeding as rapidly as suggested in initial plan? If not, why not?.....

  .....? programme too ambitious?
  .....? lack of co-operation/interest of village women.
  .....? inadequate staff/resources to carry out programme.

Reduction of Under-Fives Mortality—two-years and five-year objectives to be set when base-line data available.

Suggested two-year objective: To reduce under-fives mortality by 50% Data required: Number of under-fives deaths per 1000 live births.

Improvement in Under-fives Nutrition—to be assessed on arm circumference two-year and five-year objectives to be set when base-line data available.

Reduction in Birth Rate—(This is a measure of the success of F.P. programme.) No change expected within two years, therefore five-years objective only.

Data required: Number of births (live and still) in a year per 1000 total population.

Reduction in Maternal Morbidity and Mortality—judged by number of deaths of women of child-bearing age.

Data required: Number of deaths in women 15-44 years/ 1000 births (still and live).

Diagnosis and Treatment of Tuberculosis—systematic visiting of homes to find all cases of chronic cough. This will be the responsibility of the V.H.W. Objective achieved when all homes visited, sputum examination done on all cases of chronic cough, and treatment started on all positive cases.

Diagnosis and treatment of Leprosy—Active detection only to be started when good rapport with villagers established. Responsibility of village worker. Objective achieved when all suspect cases have had nose-blow smears plus doctor's examination and all confirmed cases have been started on treatment.

Reduction of Preventable Blindness—assessed by number of new cases of blindness presenting each year.

Increase in Health knowledge—assessed by annual 'Knowledge and Attitude' questionnaire.

From the above, the essential data to be obtained in a base-line survey was decided:

1. House number and name of head of house
2. Number of person in household
3. Number of births in past 12 months—
   (a) live
   (b) total (live and still)
4. Number of under-fives deaths in past 12 months,
5. Number of deaths in women 15-44 years in past 12 months
6. Number of cases of blindness
7. Arm circumference of all under-fives
8. Knowledge and Attitude—Questionnaire.

Initially this will be done as a 1 in 10 household survey, but may be extended to cover all homes if time permits.

Questionnaire for use in evaluation of Community Health Programme

Suggested questions

1. What do you think causes diarrhoea?
2. Should a baby with diarrhoea drink more water, less water, or the same as usual?
3. Do you know of any disease which can be prevented by injections?
4. Why are mosquitoes dangerous?

5. What can you do to prevent a new-born baby getting tetanus?
6. What causes scabies?
7. What is the best age to start giving a baby other food as well as mother's milk?
8. What foods are good to prevent night-blindness?
9. Is it better to have many children or only a few?
10. Is it a good idea for a pregnant women to be seen by a nurse before the time of delivery?

Instructions

Filling out a questionnaire requires great skill on the part of the interviewer.

1. *Tone of voice*—be very careful not to suggest a particular, by the way you ask the question.
2. *Expression*—must be 'blank' and not give any indication whether the answer is (in your opinion) correct or not.
3. Do not tell them your opinion even if they ask you for it. You are interested in what *they* think, it is not a question of right or wrong.
4. Write down exactly what they say in reply to the question—Be careful not to 'interpret'.
5. On returning to the hospital the qnestionnaires can be analysed and the answers classified:

* Agrees with health teaching
or * Disagrees with health teaching
or * "Don't knows"

Success in health teaching will be indicated by a rise in the percentage of answers which agree with health teaching in subsequent surveys. Much valuable information can also be obtained by studying the "disagree" and 'don't knows' answers.

M C.H. CLINIC RECORD

VILLAGE.....

DATE.....

1. ATTENDANCE	0-11 mth	1-4 years	5-14 years	AN	PN	Other	Total
FIRST VISIT							
RETURN VISIT							
TOTAL							

2. IMMUNISATIONS		0-11 mth	1-4 years	5-14 years	AN	PN	Other	Total
DPT	1st							
	2nd							
	3rd							
POLIO	1st							
	2nd							
	3rd							
D.T.								
T.T.								
B.C.G.								
OTHER (State)								

4. CASES TREATED

3. FAMILY PLANNING

ORAL	IUD	OTHER

APPENDIX I

RESPONSIBILITIES OF KEY PERSONNEL IN COMMUNITY HEALTH PROJECT

Introduction

A strong Community Health programme demands a team of people working together towards a common goal. The team in its broadest sense includes all the village people and their leaders as well as the VHW and the workers from the hospital or health centre. Each needs to know the aims of the project and their own particular part in it. This is especially true of the key personnel. If they are to work effectively as a team they need to have their respective roles and their interactions with one another clearly defined. Hence the importance of drawing up job descriptions.

In this particular programme the responsibilities of personnel already allotted to the programme have been written out. These responsibilities may change when new personnel are added. For instance, it is anticipated that the Community Health Nurse (C.H.N.) will be replaced by A.N.Ms for training and direct supervision of the V.H.Ws. while she herself will train and supervise the A.N.Ms. When this becomes a reality then the job description will be rewritten accordingly.

An alternative approach is to define what needs to be done and by whom and write job descriptions before personnel are appointed. This is a valid approach. Its main disadvantage is that individuals, even with the same qualifications, have different gifts and abilities which should be exploited as far as possible. Job descriptions, therefore, should be flexible enough to allow for these personal differences so that—each team member is able to utilise their special abilities and find full satisfaction in their own particular job.

Village Health Worker

The V.H.W. should show a concern for the welfare of

the people in her village, have a sympathetic attitude towards their problems, and be available to them at any time for advice and reassurance.

She is responsible to the Panchayat.

Her responsibilities will be :

1. To be a health educator to the people of her village, both by example and by instruction, taking every opportunity to pass on her knowledge of health and hygiene and seeking to promote such changes as will benefit the health of her community.

2. To care for the health of mothers and children in her village, by encouraging them to attend the M.C.H. Clinic regularly, making a note of those requiring special care, (e.g. pregnant and post-partum women, cases of malnutrition and failure to thrive, and chronic or recurrent illness), and visiting such cases regularly to see that they are following the advice given and taking treatment as instructed.

3. To conduct normal deliveries in the village in a safe and hygienic way, or to advise mothers and dais how to do so, and recognise abnormalities and when to refer to the doctor.

4. To give advice on family spacing and limitation and its importance to the health of mother and child.

5. To give first aid treatment and simple medical care, and to recognise when a doctor's opinion is necessary and to advise accordingly.

6. To watch for suspect cases of tuberculosis, leprosy and eye conditions which could lead to blindness, to refer all such cases to the doctor for diagnosis, and to follow up those on treatment.

7. To keep a record of births and deaths and causes of death and to present this to the C.H.N. at each visit.

Community Health Nurse

The C.H.N. will plan and supervise the training and work of V.H.W.s and she must be able to identify with them in such a way that they will feel free to bring their problems

to her. She must be able to delegate responsibility to them so that eventually they will assume full responsibility for primary health care and her role will be purely supervisory.

She is responsible to the doctor-in-charge, community health.

Her responsibilities will be :

1. To draw up a training programme for V.H.Ws. to supervise (and initially to conduct) their training, and to devise ways of testing their progress.

2. To establish in each village a M.C.H. clinic as a training situation for V.H.W.s and a place to which they can refer their problems.

3. To train other members of the hospital staff to be health educators either within the hospital or in the villages. As such staff become trained they will take over the primary responsibility for V.H.W. training and the C.H.N. will function increasingly in a supervisory capacity.

4. To supervise the work of V.H.W.s and to direct their on-going in-service training.

5. To collect from the V.H.W.s the vital and health statistics which will be used to evaluate the programme.

6. To keep records of health activities in the villages and to present regular reports to the doctor-in-charge of the programme.

Doctor-in-charge

The doctor-in-charge of community health is responsible for all major decisions relating to the programme, giving advice and direction to the members of his team according to the guidelines laid down in consultation with the E.H.A. Consultant in Community Health.

He is responsible to the U.M.C.

His responsibilities will be :

1. To initiate talks with village leaders and reach agreement with them on a community health project for their village. Such agreement will include decisions regarding training of V.H.Ws. and their remuneration, charges for

treatment and schemes to assist the poor, provision of accommodation for clinics and training sessions, and the setting up of a village health committee.

2. To set up a consultation clinic for cases referred by the V.H.W.

3. To establish relationship with local medical facilities to which cases requiring specialist consultation can be referred.

4. To report regularly to the D.M.O. and to invite his interest in the project.

5. To discover the felt needs of the community, whether related directly to health or not, and to investigate channels through which these needs could be met (e.g. where to obtain better grain to improve crops).

6. To collect and analyse vital and health satistics and to use these to evaluate the progress of the programme.

7. To undertake the health education of village men, and the training of male V.H.W.s.

8. To supervise the work of the C.H.N.

9. To make regular reports to the U.M.C. on the progress of the project.

APPENDIX II

OUTLINE OF COURSE FOR VILLAGE HEALTH WORKERS

Introduction

The lesson outlines presented here give the main concepts which are to be put across in each lesson. The method of putting them across will depend on the ingenuity and experience of the individual teacher, but it is important that each lesson is structured on sound educational principles :

1. Start where they are : Speak to their felt needs in words they can understand.

2. Build on what they know : the lesson should start with known facts and lead on to new facts in order to build bonds of association betweeen old and new knowledge making recall easier.

3. Involve them in the learning process : Participation by question and answers sessions, group discussion, role acting.

4. Involve as many senses as possible : hearing (talk) sight (flannelgraph, flip chart, live examples used to illustrate talk), touch (allow them to handle demonstrative materials), taste and smell (especially in relation to food and medicines).

5. Keep lessons short and to the point : fatigue inhibits learning.

6. Reinforce learning by constant regular review.

Much helpful material to aid in lesson preparation, and also a variety of visual aids are available from VHAI, C-14, Community Centre, Safdarjung Development Area, New Delhi-110016.

See also "Health Topics for Workers in Viilage India", available from E.H.A.

The order in which lessons are taught should be varied according to the health priorities of the area so that the most common and pressing problems are dealt with first. In this way the community can see at once the relevance of the programme to their needs.

Section 1

HEALTH AND HYGIENE

Lesson 1. Diarrhoea

Message : Germs cause diarrhoea; diarrhoea causes dehydration; and dehydration kills.

Introduction :

Why do so many children in the village get diarrhoea and many of them die ?

New material :

Diarrhoea is caused by germs which live in dirt.

Dirt gets into our water, into our food, and on to our hands—and so into our stomach.

Prevent diarrhoea by getting rid of the germs which cause it.

—boil water
—cook and cover food
—wash hands

Diarrhoea kills by dehydration, so give plenty of fluids to diarrhoea patients.

Demonstration :

Preparation of salt/sugar solution for oral replacement of fluid loss.

Lesson 2. Germs and Disease (1)

Message : Neglected Wounds become Infected Wounds

Review :

Diarrhoea is caused by germs which live in dirt.

Germs got into our bodies with the things we eat.

New Material :

Germs also get into our bodies through dirty cuts, and cause abscesses and wound infections.

Prevent abscesses and wound infections by keeping

cuts clean—wash with salt water and bandage with a clean cloth.

Demonstration :

Care of wounds—cleansing with salt solution and dressing with clean rags.

Lesson 3. Personal Hygiene

Message : A Clean Body is a Healthy Body

Review :

Disease is caused by germs which live in dirt

Germs which get into our stomachs cause diarrhoea.

Germs which get into cuts cause abscesses and wound infections.

New Material :

If we keep clean we avoid many illnesses

We need to take special care of our hands, our nails, our teeth, our hair, our bodies and our clothes.

If we keep all these clean we shall keep healthy.

Demonstration :

Giving a hair wash

Bathing a child

Lesson 4. Scabies

Message : A Bath and Scrub a Day Drives the Itch Mite Away

Review :

A clean body is a healthy body.

New Material :

The scabies mite likes a dirty body where it can live undisturbed.

Regular bathing and scrubbing will drive the scabies mite away.

A clean body, clean clothes, clean family, clean home means the end of the itch.

Demonstration :

Showing a case of scabies, examining the rash, and giving treatment.

Lesson 5. Germs and Disease (2)

Message : Mosquito bites mean Malaria

Review :

Germs get into our bodies with food (diarrhoea), and through cuts (infected and abscesses).

New Material :

Germs are sometimes injected by biting insects.

Mosquitoes inject malaria germs.

Mosquitoes carry malaria germs from a sick person to a well person so that the well person becomes sick.

To prevent malaria :

get rid of mosquitoes by draining standing water and spraying homes.

prevent mosquito bites by covering the whole body at night.

get rid of malaria germs by finding and treating all cases of malaria.

Demonstration :

(a) Preparation of a blood smear

(b) Tour of village to identify breeding sites

Lesson 6. Germs and Disease (3)

Message : Coughs and Sneezes Spread Disease.

Review :

Disease is caused by germs.

Germs get into our bodies with food (diarrhoea) through cuts (infected wounds and abscesses), and through insect bites (malaria).

New Material :

Germs often get into our bodies in the air we breathe.

Germs are carried in the air from a sick person to a well person especially if they cough and sneeze.

Sputum is also full of germs.

Prevent droplet infections from spreading by catching coughs and sneezes in a rag which can be burnt.

Bury or burn all sputum.

Demonstration :

Use of handkerchief and sputum receptacle, and disposal of sputum by burial.

Lesson 7. Tetanus

Message : A clean Umbilical Cord will save a baby from Tetanus

Review :

Disease is caused by germs which live in dirt. Germs get into the body through dirty wounds.

New Material :

Tetanus germs live in dung especially cow dung

Tetanus germs get into the body through dirty wounds

The umbilicus becomes a dirty wound through using a dirty knife to cut the cord, or by applying cow dung.

Tetanus kills many babies and some mothers.

Prevent tetanus by using clean equipment and dressings at delivery.

Protect yourself and your baby by having Tetanus Toxoid injections during pregnancy.

Demonstration :

Care of the umbilical cord; use of sterile blade and string and a clean dressing.

Lesson 8. Care of the sick Child

Message : Mother's care can save a Sick Child's Life

Review :

Disease is caused by germs

Germs get into our bodies with food, through cuts, through insect bites, and through our air passages.

New Material :

Even so our children will sometimes get sick and need looking after.

They need extra comfort and rest.

They need special diet and medicines.

They may need a doctor.

They all need more of mother's care and attention.

Demonstration :

Comparison of a sick child and a well child. Visit to home of a sick child to show how the lesson can be applied in a real-life situation.

Lesson 9. Disposal of Excreta

Message : Bury Excreta and get rid of Worms & Disease

Review :

Disease is caused by germs which live in dirt.

New Material :

Stools are very dirty and contain many germs.

They also contain worms and their eggs.

The eggs get on to our hands or into our food and are swallowed when we eat. This is how we get roundworm and pinworm.

Hookworm eggs hatch out on the ground and the small worms burrow through the skin of our feet and find the way to our intestine.

We only get hookworm when we go about barefoot.

Get rid of worms by-burying excreta
washing hands
wearing sandals

Demonstration :

(a) Tour of village to look at exposed excreta

(b) Instruction on use of slit-trench latrines and trowel.

(c) Examination of child with worms.

Section 2

MATERNAL & CHILD HEALTH

Lesson 1. Basic Nutrition

Message : To keep healthy we must eat the right kinds of food in the right amount.

Review :

Disease is caused by germs

We can prevent a lot of disease by clean habits.

New Material :

However, sometimes we get ill because we don't eat the right food.

We need body-building foods to make us grow and keep our muscles strong.

We need energy foods so that we can work hard and not get tired.

We need protective foods to prevent us getting sick.

Make sure your diet contains all these kinds of food in the right amounts.

Remember, your *children* need extra body-building and protective foods.

Demonstration :

(a) Show a child with protein-calorie malnutrition.

(b) Show examples of foods from each group.

Lesson 2. Feeding baby

Message : A baby will only grow up to be tall and intelligent if he is given the right food in infancy.

Review :

Sometimes we get ill because we don't eat the right food.

We need a balanced diet of body-building, energy and protective foods in adequate amounts.

Children need extra body-building and protective foods to make them grow.

New Material :

A child grows most rapidly before birth and in the first 12 months of life.

In particular his brain grows most at this time.

He needs a good diet to make his brain grow.

If his brain does not grow properly he will never be very intelligent.

Give your child a chance to be intelligent by giving him the right diet early in life.

An expectant or nursing mother must remember to eat for two people, herself and her bady.

Mother's milk is the best food for a young Infant.

After 4 to six months mother's milk is not sufficient on its own and must be supplemented by other foods.

Demonstration :

Preparation of suji with dal.

Lesson 3. Care of the Newborn

Message : A baby is happy and healthy when he is clean and well-fed.

Review :

We can prevent a lot of diseases by clean habits.

Sometimes we get ill because we don't eat the right food.

New Material :

The two most important needs of a newborn baby are—

(a) Cleanliness—The cord should be kept clean and dry.

The eyes should be wiped with a clean damp cloth.

He should be bathed regularly.

(b) The Right Food

Mother's milk is the best food.

The thin milk which flows for the first few days is good for baby and he should suckle regularly.

By the third day when the true milk begins to flow the baby should be sucking well.

Until then he may need small amounts of boiled water to prevent him getting dehydrated.

He also needs clothes to protect from cold and covering to protect from insects.

Demonstration :

Bathing a baby.

Lesson 4. Growth and Development

Message : A clean well-fed baby grows and learns fast

Review :

A child grows most before birth and in the first 12 months of life.

To grow properly he must eat the right things :

Mother's milk is the best food for a young infant.

After 4 to 6 months mother's milk is not sufficient on its own and must be supplemented by other foods.

New Material :

If a baby is growing properly he puts on weight.

A healthy baby follows the 'Road to Health'.

A healthy baby achieves the milestones on the 'Road to Health' on time.

Demonstration :

'Road to Health' flannelgraph—making up weight of all under fives present and comparing them, and pointing out any deviations from normal and the reasons for these.

Lesson 5. Immunisations

Message : Prevention of Disease by Immunisation is easier and cheaper than cure.

Review :

Disease is caused by germs.

We can prevent a lot of diseases by clean habits.

New Material :

Even so we, and especially our children do get ill sometimes.

Then we may need expensive medicine to get better.

Even with medicine many children die.

Many diseases can be prevented by injections.

Prevention is easier than cure and costs much less.

Protect your children with smallpox, BCG, DPT, and Polio vaccinations.

Protect yourselves with smallpox and tetanus vaccinations, and with typhoid and cholera injections if there is an outbreak.

Demonstration :

Showing smallpox and BCG vaccination scars, and if possible a case of polio paralysis.

Showing how to give one type of immunisation.

Lesson 6. Antenatal Care

Message : A mother's health affects the health of her unborn baby so care of a mother during pregnancy is very important.

Review :

Expectant and nursingmothers must remember to eat for two.

They can protect themselves and their babies by having Tetanus Toxoid injections.

New Material :

Expectant mothers get tired more easily and need more rest.

They often get anaemic so need to take extra iron and have their blood tested regularly.

They sometimes get an illness which can harm both the

mother and baby. This is why they need regular blood pressure and urine examinations.

The baby may be lying in the wrong position which would cause difficulty in labour.

If mothers are seen regularly these problems will be found and can be treated.

Demonstration :

How to do a routine ante-natal examination

Lesson 7—Birth of Baby

Message :

The birth of a baby is a normal process and should be interfered with as little as possible.

Review :

It is important to have clean equipment and clean dressings prepared ready for delivery.

Cleanliness may save the life of the baby and the mother.

Good ante-natal care will ensure that possible problems are detected early.

New Material:

Normal delivery occurs in 3 stages.

In Stage I the neck of the womb opens up to make a passage for the baby. This stage takes several hours and the mother must rest as much as possible and not push.

In Stage 2 the baby travels along the birth passage and is born. The mother should push hard with each pain. The midwife controls the head during delivery, eases the baby out, and ties and cuts the cord.

In Stage 3 the placenta comes away from the uterus and the next pain squeezes it out. The midwife eases the placenta out of the birth passage but must not pull on the cord or squeeze the abdomen.

After delivery the midwife cleans and wraps up the

baby, washes mother, gives her a hot sweet drink and lets her rest.

Demonstration :

Equipment required for delivery and its use.

Lesson 8—Post-natal Care and Family Planning

Message :

Spaced families are the key to healthier mothers and healthier children.

Review :

After delivery a mother needswashing, nourishment and rest.

As long she is breast-feeding she needs to eat for two.

New Material :

For two weeks after delivery the midwife must look after her carefully :

She checks that the lochia are not excessive and not offensive.

Shec hecks the abdomen to see that the uterus is getting steadily smaller.

She checks the breasts to see that the nipples do not get sore or cracked, and watches for breast engorgement.

The midwife talks to the mother about family planning both before and after delivery :

A mother who has babies too often becomes weak.

A weak mother has weak babies who get sick easily.

The way to have healthy mothers and healthy babies is to space the family.

Many methods of preventing pregnancy are available. The easiest and most readily available of these are the condom, the I.U.D., and the pill.

When the family is large enough the best way to avoid having more children is for the father or mother to have a small operation.

Demonstration :

Passing round condom, I.U.D, and pack of oral contraceptive pills and explaining their use.

SECTION (3)

DIAGNOSIS AND TREATMENT OF CERTAIN COMMON DISEASES

Although formal instruction on diagnosis and treatment will not begin until the V.H.W. has satisfactorily completed Sections (1) and (2), she will be receiving continuous teaching on these subjects as she works alongside the C H.N. In the clinic and in the village. Thus, while she is studying Sections (1) and (2) she will also watch and listen to the C.H.N. as she examines cases, and the C.H.N. must take time to explain the diagnosis and treatment to her. Section (3) training, therefore, will be concerned largely with testing the V.H.W's. knowlege of diseases and their treatment, and the format of each lesson will follow the pattern given below :

Example of Section (3) Lesson Format

(a) Test of V.H.W's knowledge of disease

—cause
—prevention
—diagnosis
—treatment
—danger signs

(b) Test of V.H.W.s knowledge of drug used in treatment

—recognition of tablets
—knowledge of dosage
—ability to dispense correctly.

Following the lesson, if her knowledge proves adequate, she will be issued with a supply of that medicine to use at her own discretion in the village. She will present all the cases she treats for review and discussion at the next clinic.

In the outline given below most lessons merely name the condition and drug to be taught. For content, reference should be made to Appendix III P, 'Standardised Treatment Regimes'. The cross reference given in brackets indicates the section in Appendix III B where the lesson material will be found in a mare expanded form. In each case the whole of the sections listed should be reviewed during the lesson and not just the one relating to the use of the drug being taught.

Lesson 1 **Diarrhoea**—use of Sulphadimidine (7)

Lesson 2 **Cuts and Abrasions, Sores,**—use of Gentian Violet (12a & 12b)

Lesson 3 **Worms**—use of Piperazine (8)

Lesson 4 **Abscess**—use of Magnesium Sulphate Dressing (12c)

Lesson 5 **Malaria**—use of Chloroquine (10b)

Lesson 6 **Scabies**—use of Benzyl Benzoate (12b)

Lesson 7 **Fever, slight**—use of Aspirin q.i.d. (10a)

Lesson 8 **Fever, high**—use of Aspirin and Sulphadimidine (10c)

Lesson 9 **Eyes**—use of Sulphacetamide 10% drops (14)

Lesson 10 **Colds and Sore Throat**—use ofAspirin q.i.d. and saline gargle (11a & 11b)

Lesson 11 **Cough**—use of Cough Sedative Tablets (11c & 11d)

Lesson 12 **Ears**—use of Chloramphenicol Ear Drops (13)

Lesson 13 **Aches** *and* **Pains**—use of Aspirin p.r.n. and Menthol Ointment (15)

Lesson 14 **Anaemia**—use of Iron Tablets and Folic Acid in Prevention (1) and Treatment (4)

Lesson 15 **Vitamin Deficiency, General**—use of M.V. in Prevention (1) and Treatment (5)

Lesson 16 **Specific Vitamin A Deficiency**—use of A and D Capsules in Prevention (2) and Treatment ment (b and 14c)

Lesson 17 **Indigestion**—use of Aluminium Hydroxide (9)

Lesson 18 **Post-natal**—use of Ergometrinic Erbolin (3)

Lesson 19 **Shock and Burns**—use of Gentian Violet (16a, b and c)

Lesson 20 **Serious Injuries**—First Aid treatment of major wounds, heads, chest, and abdominal injuries. (16e and 16f).

Lesson 21 **Broken Bones**—First Aid treatment of fractures (16g)

Lesson 22 **Tuberculosis**—Importance of chronic cough use of sputum smear in diagnosis necessity for prolonged continuous treatment V.H.W's role in case-finding and follow-up

Lesson 23 **Leprosy**—Leprosy is no different from any other disease. If caught early it can be completely cured. It spreads like tuberculosis, by breathing in or swallowing the germs

Nose-blow smears detect infectious cases
Necessity for prolonged continuos treatment
Need for special care to prevent injury and deformity

V.H. W's role in case-finding and follow-up

Where the V.H.W. proves competent in her work and in the handling of these drugs, other lessons may be added introducing new diseases and new drugs. Such additions will be at the discretion of the doctor in consultation with the C H.N.. Progression to this 'Advanced' course will not be automatic but will depend on the quality of work of the individual V.H.W.

TEACHING IN THE M.C.H. CLINIC— A METHOD OF REVISING AND EXTENDING THE KNOWLEDGE OF THE V.H.W

C.H.N. What do you notice about this child ?

V.H.W. He looks dehydrated.

C.H.N. What does the mother say is wrong with the child ?

V.H.W. Diarrhoea.

C.H.N. What kind of diarrhoea ?

V.H.W. *dust* (or *pechish*)

C.H.N. What have you been taught about the treatment of diarrhoea ?

V.H.W. Importance of fluid replacement with salt/sugar solution.

C.H.N. Do you give this only to *dust* or to all kinds of diarrhoea ?

V.H.W. To all kinds.

C.H.N. Why is it important, then to know the difference between *dust* and *pechish* ?

V.H.W. Because *pechish* needs medicine as well as fluid.

C.H.N. Yes, *pechish* needs these white tablets—Sulphonamide tablets (Shows tablets). Take a good look at them so that you will recognise them. See, we have 4 different packets of them—one with a black marker, one red, ond green, and one yellow. Why are they marked differently ?

V.H.W. The different colours are for different ages.

C.H.N. Why does age matter ?

V.H.W. Because a big body needs more medicine than a small body.

C.H.N. How old is this child ?

V.H.W. 3 years.

C.H.N. Then which packet does he need ?

V.H W. Green.

C.H N. Yes, the green packet is for 1-4 years-olds, and this is how he must take the medicine—2 tablets now then 1 tablet 4 times a day for 5 days. Now you explain to the mother. (V. H. W. repeats instructions and makes sure the mother understands).

C.H.N. Remember, all cases of *pechish*, and also cases of *dust* that go on a long time need these pills.

Now you must keep an eye on this child and see he takes the medicines correctly and also that he gets the right amount of fluids.

Is there anything which would make you worried and want to send the patient to the doctor straight away ?

V.H.W. Yes, severe dehydration, drowsiness, persistent vomittng, or failure to respond to treatment.

C.H.N. If that happens what will you tell the mother ?

V.H.W. Your child is very sick. He needs to see the doctor quickly. Don't delay but take him to the hospital now. At the hospital they can give special medicines which can save your child's life. It is the same doctor who comes here who will look after him so don't be afraid.

C.H.N. When the child gets better what do you tell the mother to do so that he won't get sick again?

C.H.W. See that you give only clean (Boiled) water and clean food with clean hands out of clean utensils.

APPENDIX III

DRUGS AND THEIR USES FOR VILLAGE HEALTH WORKERS

Introduction

In drawing up a list of drugs for use by V.H.Ws the following points should be taken into consideration :

1. What are the most pressing medical problems in tha area ?
2. What level of achievement can be expected of the V.H.W. ?

   (This depends more on intelligence and common sense than on educational status).
3. What drugs is it permissible to dispense without a doctor's signature ? (The advice of the D.M.O. may be helpful in this regard and his opinion should be respected. He may also be able to make available free supplies of certain drugs, such as Fersolate and Folic Acid, and certain vaccines, e.g, D.P.T., B.C.G)

Drug dosages have been reduced to 4 categories for simplicity of dispensing. Pills are prepacked, and the packets contain different coloured markers according to age group:

Under 1 year	Yellow
1-4 years	Green
5-12 years	Red
Adult	Black

Since the V.H.Ws are for the most part illiterate, the use of a drug is indicated by a symbol (e.g. a mosquitoe for Chloroquine, a worm for Piperazine etc) as well as being written in Hindi on the packet.

Standardised treatment regimes and treatment charges need to be decided right from the start so that the practice of the medical staff (doctor, CHN) may be consistent with what is being taught to the V.H.Ws. Doctors in particular

need to be disciplined in treating patients according to these standardised regimes unless there is some very good reason for choosing a different drug. Most of us do not find this easy, but such simplicity is essential if we are to avoid developing a dual standard of treatment. Inevitably, where that happens, the treatment offered by the V.H.W. is regarded as tnferior to that offered by the doctor, and the V.H.W.'s position is undermined. This must not be allowed to happen.

A. LIST OF DRUGS FOR USE BY VILLAGE HEALTH WORKERS

1. Iron and Folic Acid Tablets	Ante-natal cases (1) Anaemia (4 & 8d & 10b)
2. M.V. Tablets	Ante-natal cases (1) Vitamin Deficiency (5)
3. A & D Capsules	Well babies (2) Night blindness (6 & 14c)
4. Asprin Tablets	Fever (10a & 10c) Colds (11a) Sore Throat (11b) Cough with fever (11c) Aches and Pains (15a, 15b, 15c)
5. Chloroquine Tablets	Suspect Malaria (10b)
6. Sulphadimidine Tablets	Diarrhoea (7b) High or persistent fever (10c) Cough with fever (11c) Boils and abscesses (12c)
7. Piperazine Tablets	Roundworm (8a) Pinworm (8b) Tapeworm (8c) Hookworm (8d)
8. Aluminium Hydroxide Tablets	Indigestion (9)
9. Ergometrine (Erbolin) Tablets	Post-natal cases (3)
10. Cough Sedative Tables	Dry cough (11d)
11. Chloramphenicol Ear Drops	Running ears (13a)

12. Sulphacetamide 10% Eye Drops	Sticky eyes (14a) Gritty eyes (14b)
13. Magnesium Sulphate Dressing	Boils and Abscesses (12c)
14. Gentian Violet Paint	Cuts and Abrasions (12a & 16d) Sores (12b) Minor burns (16b)
15. Benzyl Benzoate	Scabies (12d)
16. Menthol Ointment	Muscle and bone pains (15b)

The numbers in brackets refer to the sections in Appendix III B, 'Standardised Treatment Regimes', where the uses of the drugs are discused.

B. STANDARDISED TREATMENT REGIMES

1. Ante-natal cases

Routine administration of iron, folic acid and M.V. tablets.

Dosage : Iron tab. 1 t.i.d.
Folic Acid tab. 1 t.i.d.
M.V. tab. 1 daily

2. Well babies

Routine administration of A & D capsules

Dosage : A & D Caps. 1 daily

3. Post-natal cases

Routine administration of ergometrine (Erbolin) tablets

Dosage : Ergometrine tab. 1 b.i.d. x 3 days after delivery

4. Anaemia

Symptoms : Pallor and weakness

Treat with iron and folic acid tablets and give instructions about diet.

Dosage :

Under 1 year	1/2 tab. of each daily
1—4 years	1 tab. of each daily
5—12 years	1 tab. of each b.i.d.
Adult	1 tab. of each t.i.d.

Danger Signs : Difficulty in breathing
Swelling of legs and body
] Refer to doctor IMMEDIATELY

All severe cases should be referred to the doctor of investigation : e.g. suspect hookworm—refer with stool specimen
suspect Malaria—refer with blood smear.

5. Vitamin Defficiency, General

Symptoms : Dry brittle hair with discolouration
Cracked mouth angles and smooth tongue
Flaking skin.

Treat with M.V. and give instructions about diet

Dosage : All ages 1 tab. t.i.d.

6. Night Blindness

Symptoms : Dimness of vision at night.

Treat with A & D capsules and advise to eat green vegetables

Dosage : All ages 1 capsule daily

Danger Signs : Photophobia
Dry, cloudy cornea
] Refer to doctor IMMEDIATELY

7. Diarrhoea

(*a*) *Mild*

Of short duration, no fever, no blood or mucus, little or no dehydration.

Treat with rehydration fluid only (Salt/Sugar solution)

(*b*) *Severe*

Lasting more than 2 days, with fever, or with blood or mucus.

Treat with sulphadimidine tablets (500 mg)

Dosage :	Under 1 month	DO NOT GIVE	
	Under 1 year	1 tab. stat.	1/2 tab. q.i.d. x 5
	1—4 years	2 tab. stat.	1 tab. q.i.d. x 5
	5—12 years	2 tab. stat.	1 tab. q.i.d. x 5
	Adult	4 tab. stat.	2 tab. q i.d. x 5

Danger Signs : Severe dehydration)
Drowsiness
Failure to respond to treatment
Persistent vomiting
] Refer to doctor IMMEDIATELY

8. Worms

(*a*) *Roundworms*

Symptoms : Large worms, vomited or parsed in stool.
Treat with piperazine tablets (300 mg)

Dosage :	1—4 years	6 tab. every night x 3
	5—12 years	9 tab. every night x 3
	Adult	12 tab. every night x 3

(*b*) *Pinworms*

Symptoms : Very small worms, causing severe itching round the anus.

Treat with piperazine tablets (300 mg)

Dosage : As for roundworm, but repeat after 1 week

(*c*) *Tapeworm*

Symptoms : Flat white squirming segments in stool.

Give Piperazine (Dosage as for 8a) to remove Roundworm then refer to doctor (for treatment with TCE or Mepacrine)

(*d*) *Hookworm*

Symptoms : *Anaemia*, often severe, and abdominal pain.

Give piperazine (Dosage as for 8a) to remove Roundworm then refer to docter with fresh stool specimen (for treatment with TCE or Bephenium).

Treat anaemia with iron and folic acid tablets (Dosage as for 4)

9. Indigestion

Symptoms : Epigastric pain, flatulence, or heartburn

Treat with aluminium hydroxide tablets and advise to avoid hot spicy foods.

Dosage : 1 tab. p.r.n. (maximum dosage 6 tab. per day)

10. Fever

(*a*) *Slight*

less than 3 days, no indication of cause

Treat with aspirin tablets and advise to increase fluid intake

Dosage :	Under 3 months	DO NOT GIVE
	Under 1 year	1 (75 mg), tab. t.i.d. x 3
	1—4 years	2 (75 mg). tab. t.i.d. x 3
	5—12 years	1 (300 mg), tab. t.i.d. x 3
	Adult	2 (300 mg), tab. t.i.d. x 3

(*b*) *Periodic*—Suspect *Malaria*

Symptoms : Fever with shivering coming every second or third day.

Take blood smear and treat with chloroquine tablets (250 mg)

Dosage :	Under 1 year	1/2 tab. stat.	1/4 tab. every night x 3
	1—4 years	1 tab. stat.	1/2 tab. every night x 3
	5—12 years	2 tab. stat.	1 tab. every niget x 3
	Adult	4 tab. stat.	2 tab. every night x 3

Treat anaemia with Iron and Folic Acid Tablets (Dosage as for 4).

(*c*) *High*

skin burning to touch, patient feels dry and thirsty, often drowsy, obviously quite ill.

Give ropid sponge p.r.n., and advise increased fluid

intake. Look for cause of fever and treat accordingly. (e.g. ear discharge, malaria).

If no cause found treat with sulphadimidine (Dosage as for 7b) and aspirin (Dosage as for 10a) and refer to doctor for Investigation.

Danger Signs :

Convulsions and increasing drowsiness
Persistent high fever
Dehydration
Failure to sweat

] Refer to doctor IMMEDIATELY

11. Respiratory Infections

(a) *Colds*

Symptoms : Running nose, sore throat, and cough
Treat with aspirin (Dosage as for 10 a)

(*b*) *Sore Throat—Suspect Tonsillitis*

Symptoms : Throat red and inflamed, pain on swallowing.

Treat with aspirin (Dosage as for 10 a) and saline gargles and refer to doctor.

(*c*) *Cough with fever*

Or lasting more than one week, or with much sputum
Treat with sulphadimidine (Dosage as for 7 b) and aspirin (Dosage as for 10 a) and refer to doctor for investigation.

Danger signs :

Blue lips
Difficulty in breathing
Coughing up blood

] Refer to doctor IMMEDIATELY

(*d*) *Dry Cough*

No other symptoms
Treat with cough sedative tablets
Dosage : 2 tab p.r.n. (maximum frequency q.i.d.)

12. Skin Conditions

(*a*) *Cuts and Abrasions*

Wash and apply gentian violet paint
Cover with a clean cloth.

(*b*) *Sores* (Wet, with pus)

Wash and apply gentian violet paint
Cover with a clean cloth
Repeat daily.

(*c*) *Boils and Abscesses*

Symptoms : Hot, red, tender swelling, in or under the skin. May have a 'head' containing pus.

Wash and apply magnesium sulphate dressing.
Start sulphadimidine (Dosage as for 7 b)
Refer to doctor.

(*d*) *Scabies*

Symptoms : Itching skin with excoriations due to scratching.

Give bath and apply benzyl benzoate to whole body
Wash all clothes and dry in sun
Treat all the family at once.

13. Ears

(*a*) *Running ears*

Purulent discharge and earache
Clean out pus with swab-stick and apply chloramphenicol ear drops.
Refer to doctor.

Danger Signs

Drowsiness
Fits
Swelling or tenderness behind ear

] Refer to doctor IMMEDIATELY

(*b*) *Deafness*

Refer to doctor for investigation

(c) *Foreign Body in Ear*

Avoid getting water in the ear
Do not attempt to remove
Refer to doctor as quickly as possible.

14. Eyes

(a) *Sticky Eyes*

Red with sticky discharge.

Wipe pus away with clean cloth soaked in boiled water, then apply sulphacetamide 10% drops.

Repeat q.i.d. until better.

Danger signs: Redness around cornea
Haziness of cornea
Much swelling of lids
] Refer to doctor IMMEDIATELY

(b) *Gritty Eyes*

Suspect *Trachoma*—'gritty' sensation on blinking
—redness not marked

Treat with sulphacetamide 10% drops q.i.d. x 10

If no improvement refer to doctor.

(c) *Night Blindness*

Dimness of vision at night.

Treat with A & D capsules and advise to eat green vegetables.

Dosage: 1 cap. daily

Danger signs: Photophobia
Dry, cloudy cornea
] Refer to doctor IMMEDIATELY

15. Aches and Pains

(a) *Headache*

Treat with aspirin p.r.n.

Dosage:			
	Under 1 year	Unnecessary	
	1-4 years	2 (75 mg) tab. p.r.n.	] maximum
	5-12 years	1 (300 mg) tab. p.r.n.	frequency
	Adult	2 (300 mg) tab. p.r.n.	] q.i.d.

If severe or persistent, refer to doctor.

Danger signs : Convulsions
Neck stiffness
Vomiting
Photophobia
] Refer to doctor IMMEDIATELY

(*b*) *Muscle and Bone Pains*

Treat with asprin p.r.n. (Dosage as for 15a) and menthol ointment.

If severe or persistent refer to doctor for investigation.

(*c*) *Toothache*

Bite on Cloves with painful tooth

Treat with aspirin p.r.n. (Dosage as for 15 a) and refer to doctor.

(*b*) *Acute Abdominal Pain*

Refer to doctor IMMEDIATELY

16. Accidents

(*a*) *Shock*

Skin pale, cold, and clammy; pulse weak and rapid.

May occur with certain illnesses and often with injuries.

Lay patient down and raise legs slightly higher than head.

Cover with a blanket

Give hot sweet drink if conscious

Refer to doctor IMMEDIATELY

(*b*) *Burns-Minor*

Minor—limited extent, reddening of the skin with or without blistering.

Soak the burn in cold water for 15 minutes

Apply gentian violet paint and cover with a clean cloth

Change dressing daily.

Danger signs : If serious discharge becomes purulent (indicating secondary infection) refer to doctor.

(*c*) *Burns-Major*

Major—large area affected, or with blanching or blackening of skin.

Do not remove clothes

Cover burn with a clean cloth.

Treat for shock (see 16a) and refer to doctor IMMEDIATELY.

M.B. If clothing catches fire, roll the person on the ground to extinguish the flames. Trying to remove blazing clothes will only result in more severe burns.

(*b*) *Open Wounds-Minor*

Minor-abrasions and superficial cuts (not gaping, bleading easily controlled)

Wash and apply gentian violet paint,

Cover with a clean cloth.

(*e*) *Open Wounds—Major*

Major-gaping wound, or with severe bleeding, or loss of skin cover.

Wash and cover with a clean cloth or pressure dressing to control bleeding.

Treat for shock (see 16a)

Refer to doctor IMMEDIATELY

(*f*) *Head, Chest, or Abdominal Injuries*

Give first aid treatment to wounds (including pressure dressing if necessary to control bleeding or to close an open chest wound).

Treat for shock (see 16a)

Refer to doctor IMMEDIATELY

(*g*) *Broken Bones*

Do not move until appropriate splinting applied.

Splint and treat for shock (see 16a)

Refer to doctor IMMEDIATELY

TREATMENT CHARGES FOR VILLAGE HEALTH WORKERS

(as at April 1976)

	Name of Drug	*Quantity*	*Price*
1.	Iron tables	21	0.50
		14	0.35
		7	0.20
2.	M.V. tablets	21	1.00
		7	0.35
3.	A & D capsules	7	0.20
4.	Aspirin (300 mg) tablets	18	0.35
		9	0.20
	Aspirin (75 mg) tablets	18	0.15
		9	0.08
5.	Chloroquine tablets	10	1.00
		5	0.50
		$2\frac{1}{2}$	0.25
		$1\frac{1}{4}$	0.12
6.	Sulphadimidine tablets	44	6.00
		22	3.00
		11	1.50
7.	Piperazine tablets	12	0.50
		9	0.35
		6	0.25
8.	Aluminium hydroxide tablets	20	0.30
9.	Ergometrine (Erbolin) tablets	6	0.40
10.	Cough sedative tablets	20	0.15
11.	Chloramphenicol ear drops	1 bottle with dropper	1.80
12.	Sulphacetamide 10% eye drops	1 bottle with dropper	2.10

13.	Magnesium sulphate powder	30 gm	0.10
14.	Gentian violet paint	1 bottle	
15.	Benzyl benzoate	1 bottle	
16.	Menthol ointment	1 tin	

BIBLIOGRAPHY

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